SYSTEMIC CHILD FATALITY REVIEW 2021 ANNUAL REPORT

Systemic Child Fatality Review – 2021 Annual Report

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Introduction

The New York City's Administration for Children's Services (ACS) is charged with investigating alleged abuse and neglect of children residing in New York City. ACS is also responsible for providing services and supports to New York City's families in an effort to keep children safe at home. During 2021, ACS responded to more than 55,000 reports of child maltreatment, concerning almost 64,000 children. These reports were consolidated into 43,632 investigations and 4,013 Collaborative Assessment, Response, Engagement and Support (CARES) cases.

In 2021, ACS investigated 102 child fatalities reported to the Statewide Central Register (SCR) with about 48% (N=49) of these children in families that had no history of prior contact with ACS. Child fatalities reported to the SCR and referred to ACS comprise about 0.2 percent of all child protection cases. The death of a child in a family with which ACS has had contact requires special attention and review, and these are the focus of this report.

This report focuses on child fatalities during calendar year 2021. It outlines how ACS responds to child fatalities, summarizes demographic data, and provides systemic findings from cases reviewed. Due to the small number of fatalities when compared to the larger pool of child welfare cases touched by ACS, readers are cautioned against generalizing findings in this report. The child fatality cases examined in this report are neither a random nor a representative sample of all families involved in the city's child welfare system. The purpose of the case reviews and fatality data analyses is to gather insights that we can incorporate into our larger quality assurance processes to strengthen the child welfare system for all families with whom ACS has contact.

This report is published pursuant to Local Law 19 of 2018[1] which requires ACS to issue a report on its child fatality reviews. This is an annual obligation, with a report on fatalities from each calendar year to be issued no later than 18 months after the end of the year. The law requires that this report include, but not be limited to, the following:

a. The number of fatalities of children known to ACS for the applicable year;

b. The manner and/or cause of death in such fatalities;

c. The age, gender, race and ethnicity of children with fatalities for the previous year;

d. Any relevant trends and systemic recommendations, including opportunities for inter-agency collaboration; and

e. A summary of any case practice findings and agency policy changes made in response to child fatalities in the previous 12 months.

[1] 2018 N.Y.C. Local Law No. 19, N.Y.C. Admin. Code §§ 21-915

The New York State Office of Children and Family Services (OCFS) and the New York City Department of Health and Mental Hygiene (DOHMH) also produce annual reports on child fatalities using other criteria for inclusion.

In 2018, ACS adopted a safety science approach[2] to reviewing fatalities, based on innovations in aviation, health care and other industries to improve safety. The safety science approach encourages analyzing and applying data to drive learning and system improvements. ACS's Systemic Child Fatality Review (SCFR) process emphasizes a culture of system accountability and implements systemic methods of learning to identify and address underlying issues rather than deploying quick fixes. The SCFR includes a review of fatality cases that examines the complex interplay of systemic factors, such as policies, workloads, availability of resources, supervision and training, among many other influences that may impact case practice and decision-making. It promotes a culture of openness and shared agency-wide accountability, in order to strengthen investigative practice and the child welfare system as a whole. Using this approach, ACS seeks to learn and ultimately improve the system's ability to support quality case practice, secure safe outcomes for children and improve services to their families.

This report reviews 53 child fatalities from calendar year 2021 that occurred in families that were "known" to ACS because of active involvement in an ACS investigation or services at the time of the fatality, or because of such involvement in the preceding 10 years.

[2] Technical assistance to implement the model in ACS was provided by Collaborative Safety LLC, and the Center for Innovation in Population Health at the University of Kentucky through The National Partnership for Child Safety, established in partnership with Casey Family Programs.

New York City's Review of Child Fatalities Alleging Maltreatment

The New York Statewide Central Register (SCR) receives all reports of suspected child abuse and maltreatment for anyone under 18 years old. Reports may come from professionals mandated by law to report (e.g., medical staff, school officials, social service workers, law enforcement), as well as from the general public. Among the reports the SCR receives are cases of child fatalities in which maltreatment may have been a factor, including reports received from the medical examiner or coroner. Additionally, any fatality that occurs during an open child protective investigation, while a family is receiving prevention services, or while a child is placed in foster care, must be reported to the New York State Office of Children and Family Services (OCFS) even if the circumstances of the fatality did not raise suspicion of abuse and/or maltreatment.

The New York City Office of the Chief Medical Examiner ("the ME") determines the cause and manner of a child's death. The cause of death is the injury, disease, or condition that resulted in the fatality, such as blunt trauma, smoke inhalation, or bronchopneumonia. The manner of death is determined by the findings of the ME's autopsy examination and the circumstances of the death. The ME certifies the "manner" as having been an accident, homicide, natural, suicide, therapeutic complications, or undetermined.[3] These classifications are administratively determined and may differ from other jurisdictions, which can make comparisons across systems challenging. For example, the ME may classify a case as "homicide" in which a child died in a fire where s/he was left alone without adult supervision. Another source of variation in "manner of death" classifications, relates to sleep related injury deaths where the child's sleeping conditions or surface may have contributed to the fatality. These deaths are often classified as "undetermined" by the ME in New York City, though this classification varies for similar cases both within New York City and in other state and county systems.

Table 1, below, shows that of the 102 child fatalities reported to the SCR in 2021 alleging maltreatment in association with a child's death, 52% (n = 53) occurred in families that had involvement with ACS[4] in the past 10 years. Subsequent sections of this report focus only on those fatalities. Table 1 also provides an overview of all fatalities reported to the SCR and investigated by ACS in 2021 (see Table 2 for data on cases "known" to ACS).

[3] As noted, the manner of death is an administrative distinction made by the Office of the Chief Medical Examiner. In New York City, the Medical Examiner uses the undetermined category when the manner or cause of death cannot be established with a reasonable degree of medical certainty. Deaths are determined to be from therapeutic complications when a medical device failure caused the death. Please see Appendix 1 for additional details.

[4] See Case Review Criteria section of this report for full definition of "known to ACS."

Table 1. Manners of death for all 2021 child fatalities reported to SCR

	2021 Child Deaths in Families Known* to ACS in Previous Decade		2021 Child Deaths with No ACS History		All 2021 Child Deaths Reported to the SCR	
Manner of Death	**N**	**%**	**N**	**%**	**N**	**%**
Accident	**11**	**21**	**9**	**18**	**20**	**20**
Homicide	**10**	**19**	**5**	**10**	**15**	**15**
Natural	**12**	**23**	**7**	**14**	**19**	**19**
Suicide	**0**	**0**	**1**	**2**	**1**	**1**
Undetermined	**19**	**36**	**19**	**39**	**38**	**37**
Therapeutic Complications	**0**	**0**	**0**	**0**	**0**	**0**
Pending ME determination	**1**	**2**	**4**	**8**	**5**	**5**
ΨOther	**0**	**0**	**4**	**8**	**4**	**4**
Total	**53**	**101**	**49**	**99**	**102**	**101**

Percentages may not equal 100 due to rounding

* A family is considered "known" to ACS if an adult in the household has been the subject of an allegation of child abuse or maltreatment reported to the NY State Central Register within the last 10 years.

Ψ The death did not fall under the jurisdiction of the Office of the Chief Medical Examiner or no autopsy was performed. This includes children who were not autopsied for religious reasons or children where the hospital certified the cause of death.

When the SCR receives a report of a child's death in New York City, the report is forwarded to the ACS Division of Child Protection (DCP). DCP investigates all fatalities referred by the SCR and makes determinations regarding the circumstances of the deaths. Under the standard of evidence in effect during 2021, when a DCP investigation found "some credible evidence" that abuse or neglect may have taken place in relation to any of the allegations, the report was defined as "indicated." [5] Alternatively, if there is no credible evidence of maltreatment, the report was classified as "unfounded." Some investigations result in an indication for some, but not all, of the allegations. Fatality investigations often include other allegations of maltreatment which may be "substantiated", but the child protective team may have "unsubstantiated" the fatality allegation after concluding that the parent or caretaker did not contribute to the fatality.[6] Such cases may involve an allegation of educational neglect as "substantiated" for the deceased child and/or a sibling, but the fatality allegation may be "unsubstantiated." In addition to DCP investigations, the New York City Police Department

[5] In 2022, the standard for indication was changed by New York State statute to "Fair Preponderance of the Evidence."

[6] A child maltreatment allegation is either "substantiated" or "unsubstantiated" based on the evidence gathered. The child maltreatment report is deemed "indicated" if one or more of the allegations are "substantiated." The child maltreatment report is deemed "unfounded" when all of the allegations in the report are "unsubstantiated." Therefore, an allegation may be "unsubstantiated" with respect to the fatality itself, but the report "indicated" if other allegations within the same SCR report are "substantiated."

and District Attorney also investigate child fatalities to determine if there might have been criminal culpability and whether or not to pursue prosecution.

Case Review Criteria

The Child Fatality Review Team, consisting of specially trained Case Reviewers, screens each child fatality case reported to the SCR for ACS history to determine whether the family was "known" to ACS[7]. A family is considered "known" if it meets any of the following criteria:

a. Any adult in the household that has been reported to the SCR as the subject of an allegation of child abuse or maltreatment within 10 years preceding the fatality;
b. When the fatality occurred, ACS was investigating an allegation against an adult in the household; OR
c. When the fatality occurred, a household family member was receiving ACS services such as foster care or prevention services.

If the family is "known", the Case Reviewers assess the case to determine the appropriate review track. There are two possible tracks.

1. There is an open investigation or an open case with prevention and/or foster care services; or there was a prior ACS case within the past 3 years; or the Office of the ACS Commissioner requested a review.
2. A prior ACS case was closed more than 3 years ago but within 10 years.

Cases that fall within category one receive a summary and are eligible for the ACS Systemic Child Fatality Review Process, while cases in category two receive a case summary only.

[7] Although the family may have child welfare history, it does not mean that the deceased child(ren) was the maltreated child(ren) or alive during the prior ACS involvement.

ACS Systemic Child Fatality Review (SCFR) Process

Upon notification of a child fatality from the SCR, the Division of Child Protection (DCP) takes immediate action, in accordance with OCFS guidelines, to initiate the investigation and ensure the safety of any surviving sibling(s) and/or family members. During the investigation, as more information becomes available, DCP may take additional actions to assure child safety. The Child Fatality Review Team (CFRT), within the ACS Division of Policy, Planning & Measurement, also receives notification of each fatality. The CFRT assesses the fatality to determine whether it falls within the review criteria. If it does, the team implements the Systemic Child Fatality Review (SCFR) process.

Once a child fatality is determined to fall within the review purview, the Child Fatality Review Team examines the family's child welfare history with ACS and other jurisdictions, as well as available autopsy reports and records from service providers that had contact with the family. Additionally, in order to understand family and child functioning prior to the fatality, the team examines the child welfare histories of all adults living in the household, whether related to or not, as well as those involved with the child, such as parents, significant others, grandparents, aunts/uncles, and others outside the household with known caregiving responsibilities.

The Child Fatality Review Team completes a case summary which includes a technical review of the case history from available databases. Upon summary completion, the case is presented to the ACS Interdivisional Team (IDT), consisting of cross divisional ACS staff, where possible key learning points or areas of study are discussed and the decision is made on whether a more comprehensive analysis of the case will surface internal and external systemic influences that impact child safety. When cases are selected for a full review, staff involved with the corresponding learning points are invited to participate in a human factors debrief. In 2021, there were 39 cases eligible for the SCFR process.

Human factors debriefings are facilitated opportunities for staff to share, process and learn from their experiences working with the family, as well as explore critical decisions and interactions throughout ACS's involvement with the family. Debriefings add to the technical review by uncovering and understanding the elements of decision making. Debriefings are voluntary and typically involve direct service staff and their supervisors, but may include other staff, such agency attorneys, where necessary. During debriefings, all efforts are made to create a safe and supportive environment for staff to identify opportunities for learning and improvement.

Cases selected for a full review are mapped, a process whereby local multidisciplinary teams (Mapping Teams) made up of staff from the various ACS divisions, including those in direct service, discuss local, regional and regulatory conditions or processes that affect case practice and decision making. Information gathered from the case review, human factors debriefs and mapping sessions is analyzed to identify systemic influences and key findings. In 2021, ACS added Systems Learning and Improvement Sessions (SLIS) to the SCFR process to further

explore systemic themes as well as brainstorm possible recommendations for consideration and implementation by ACS leadership.

2021 Cases Reviewed

Manner of Death

In 2021, there were 53 fatalities of children in 53 families that had been the subject of an investigation or otherwise received services from ACS within the last 10 years, or who were receiving services or were the subject of an investigation at the time of the fatality. The most common "manners" of death as certified by the ME were "undetermined" (n = 19, 36%), followed by "natural" (n = 12, 23%), "accident" (n = 10, 19%) and "homicide" (n = 10, 19%) (See Table 2)[8]. There was one case with a pending autopsy at the writing of this report.

Table 2: 2021 Manners of Death for Children in Families Known to ACS

Manner of Death	Total 2021	
	N	%
Accident	11	21
Homicide	10	19
Natural	12	23
Suicide	0	0
Undetermined	19	36
Therapeutic Complications	0	0
Pending ME Determination	1	2
Total	53	101

Percentages may not equal 100 due to rounding

Case Demographics and Family Characteristics

The Child Fatality Review Team examined the child welfare case record of each family in which a fatality occurred and for each case collected information on family demographics and characteristics, including the race and/or ethnicity of the parents/caretakers; the number and ages of children in the family; and the gender of the children.

[8] Appendix A provides a description of what the Medical Examiner consider when making a manner of death determination.

The review team also gathers information on the presence of potential risk factors, such as:

a. Whether the child had any documented developmental, medical or mental health conditions;
b. Whether the family had a history of homelessness within four years prior to the fatality, and whether the family was residing in shelter at the time of the fatality;
c. Extent of history with ACS, including the parents' history with child welfare as a child and the number of previous investigations of the family;
d. Whether the mother was under eighteen when her first child was born, as well as the ages of the mother and father/male involved at the time of the fatality;
e. Identification in the case record of parent or caregiver mental health condition;
f. Identification in the case record of parent or caregiver substance use;
g. Identification in the case record of household domestic violence within the last four years;
h. Whether the family had an open case at the time of the fatality.

The following is a review of case characteristics for the 2021 fatalities; Table 3 provides demographic information for the 53 cases.

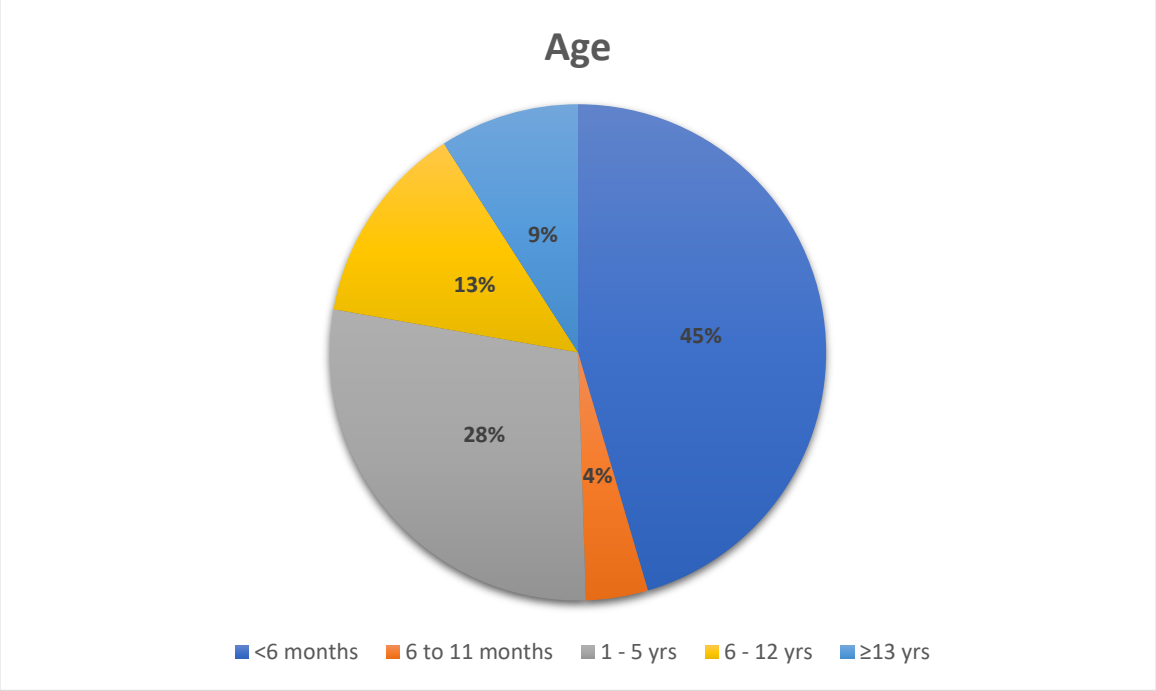
Table 3: Demographics

Demographics	n	%
Race (of mother, n = 53)		
Asian	5	9
Black	33	62
Hispanic	8	15
Pacific Islander	0	0
Native American	0	0
Biracial/Multiracial	0	0
White Non-Hispanic	6	11
Not Available	0	0
Other	1	2
Unknown	0	0
Gender (of child n = 53)		
Male	37	70
Female	16	30
Age (of child n = 53)		
<6 months	24	45
6 to 11 months	2	4
1 to 5 yrs	15	28
6 to 12 yrs	7	13
≥13 yrs	5	9

Percentages may not equal 100 due to rounding

Mothers were disproportionately Black/African American/non-Hispanic (62%), followed by Hispanic (15%), White (11%) and Asian (9%). Data was also collected on the fathers or males involved with the family. For the 50 males where information was available, sixty-two percent (n = 31) were identified as Black/African American/non-Hispanic, while 18% (n = 9) were Hispanic, 10% (n = 5) Asian and 8% (n = 4) were White. One male was identified as biracial and there was no race/ethnicity data available on males in three cases.[9] (See Table 9 in Appendix B for parents' race/ethnicity in 2021 child fatalities in families known to ACS, as well as fatalities reported to the SCR for which there was no prior ACS involvement.)

Figure 1. Age of Child at Time of Fatality



Children at greatest risk of fatality were of the youngest ages, consistent with prior years. In 2021, the average child age was 3.6 years while the median age was 1.1 years, both categories were higher than the preceding three years, 2020 (2.3 years and 3.9 months, respectively), 2019 (3.2 years and 6.8 months, respectively) and 2018 (3.1 years and 6.6 months, respectively). Children's ages ranged from newborn to just under 18 years. Almost half (49%, n = 26) of the fatalities were of infants under the age of one, and of these, ninety-two percent (n = 24) were less than six months of age. Children under the age of six, including infants, accounted for 77% of 2021 fatalities. Overall, a significantly larger proportion of the 53 children

[9] All race and ethnicity data is based on information available in CONNECTIONS.

who died were male (70%) than female (30%). Male deaths accounted for 73% (n = 19) of the 26 children who were less than one year of age.

A fatality investigation concludes with the child protective investigative team making a determination regarding the fatality allegation made in the SCR report, as well as any additional allegations included in the report, such as inadequate guardianship or lack of supervision. Just over half of the cases were indicated for at least one allegation (n = 27, 51%), with 32 percent (n = 17) of the cases indicated for the fatality itself. Twenty-six cases were unfounded, i.e., no allegation was substantiated (see table 5 in Appendix B). While a fatality allegation may be substantiated, this does not mean the Medical Examiner deemed the death a homicide or that the parent/caretaker intentionally harmed the child. A close reading of the case circumstances is necessary to fully understand the substantiation decision made by the child protection team. For example, in 2021, fatality allegations were substantiated in some cases that the Medical Examiner ruled Accident or Undetermined.

Many of the families that were known to ACS prior to the fatality faced multiple challenges, such as recent or ongoing homelessness (23 percent of families in cases reviewed), and a recent history of domestic violence (within the last four years), which was noted in 55 percent of the cases reviewed. Forty-five percent (n = 24) of the mothers had histories of ACS involvement as children and of those, more than a third (38%, n = 9) had a history of foster care placement as children. For the males involved with these families (where information was available, n = 51), 41 percent (n= 21) had histories of ACS involvement as children, and six had a history of foster care placement. There were six families residing in a shelter at the time of the fatality; four of the six had an active ACS case at the time of the fatality.

Reviews of the case records indicated that the average age of mothers in these cases was 31.0 years of age at the time of the child's death, more than three year older than the 27.7 years recorded for mothers in 2020. The median age of these mothers was 29 years, compared to the 2020 median of 26.5 years. All of the mothers of children who died in 2021 were 18 years old or older. Consistent with previous years, the mothers had, on average, about three children. Forty-three percent (n = 23) of the mothers had current or prior substance use issues, and 45 percent had current or ongoing mental health concerns (diagnosed or undiagnosed) noted in the case record. An adult male was involved with the family in 96 percent (n = 51) of the cases reviewed. Of the identified males, 69 percent (n = 35) were fathers of the deceased child. Where information was available on the male known to be a part of the household and/or in a caregiving role, in 35 percent of the cases, current or prior substance use was recorded. Current or past mental health concerns were noted in almost a quarter (24%, n = 12) of the cases.

Additional Case Characteristics and Related ACS Initiatives

Sleep-Related Injury Deaths

In 2021, there were 20 fatalities in families known to ACS that included notations of sleep-related injuries or unsafe sleep conditions, either from the Medical Examiner (ME) findings or from a review of the ACS investigation of the fatality. While unsafe sleep is not a manner or cause of death certified by the ME, the ME may make note of the presence of contributing unsafe sleep factors when determining the manner of death.

The ME often designates and records the manner of death for sleep-related injury deaths as "undetermined" or "accident." In New York City, the ME uses the undetermined category when the manner or cause of death cannot be established with a reasonable degree of medical certainty. This is common in cases where an unsafe sleep condition is present but the role of the hazard in the fatality cannot be determined following an autopsy, such as when an infant is found unresponsive after bed-sharing with an adult, or alone in a crib or bassinet in which blankets or pillows are present. For the 20 cases noted on Table 6, the manner of death was "undetermined" for 16 cases, two were deemed "accident" and two were classified "natural". Bed sharing with an adult was the most commonly recorded factor, noted in nine of the cases. Other unsafe sleep conditions included items being in the crib or bassinet and the child being placed face down on the sleep surface. Of the 20 sleep-related fatalities, all but two of the children were under six months of age. Seventy percent (n = 14) of the children were male and 30% (n = 6) were female.

ACS Safe Sleep Strategy

Between 40 and 50 babies in New York City die from a sleep-related injury each year. The Centers for Disease Control and Prevention (CDC) estimates that nationally about 3,400 babies in the US are lost to sleep-related deaths each year. The CDC's analysis also shows that placing babies on their side or stomach to sleep was more common among mothers who were Black/Non-Hispanic, younger than 25, or had 12 or fewer years of education.[9]

In 2015, a Mayoral Initiative established the NYC Infant Safe Sleep Initiative to prevent sleep-related infant injury deaths and address long-standing disparities to promote and protect the health and well-being of the youngest and most vulnerable New Yorkers. The initiative focuses on community engagement, public awareness campaigns, free training and resources, collaborations and stakeholder partnerships to increase infant survival in NYC. In addition, since 2017, the initiative has convened an annual summit of professionals and advocates to inform and unite a community of action focused on preventing the tragic loss of children to sleep-related infant injury deaths.

In August 2021, ACS established the Office of Child Safety and Injury Prevention (OCSIP) within the Division of Child and Family Well-Being. In addition to housing the NYC Infant Safe Sleep Initiative, the office efforts include public education, training, and resource distribution to help

parents and child serving professionals reduce or eliminate preventable child injuries and fatalities that primarily affect children under age six, specifically, Shaken Baby Syndrome and unintentional child poisoning caused by exposure to inadequately stored cannabis edibles, medications, household cleaners and other substances.

Between January 2022 and April 2023, OCSIP continued its safe sleep efforts. The Safe Sleep team:

- Distributed more than 17,000 Safe Sleep Toolkits to discharging maternity patients at all 11 NYC H+H medical centers.
- Sustained a hybrid training model—providing both in-person and virtual trainings for parents, caregivers and child-serving professionals and highlighting parental stress, fatigue, and sleepiness as potential barriers to safeguarding infants during sleep.
- Provided virtual and in-person infant safe sleep training to more than 7,300 parents and caregivers and 2,200 child-serving professionals. In addition, more than 900 child welfare professionals completed the Safe Sleep e-Learn Course, "Communicating Infant Safe Sleep Practices," designed to dispel common myths and misconceptions about infant sleep, identify the behaviors that may contribute to sleep-related injury deaths, establish and practice Safe Sleep habits, and guide child-serving professionals on how to lead a strengths-based conversation with parents and caregivers around implementing infant safe sleep practices.
- Distributed free resources, including the safe sleep brochure, video, "Breath of Life: The How and Why of Infant Safe Sleep," wearable blankets (sleep sacks), and portable cribs to support NYC parents and caregivers in safeguarding infants while they sleep.
- Conducted crib demonstrations at in-person community events and in trainings of parents and caregivers to model a safe sleeping environment and simulate the suffocation risks associated with stomach/side sleeping and use of excess bedding like blankets, quilts, and comforters.
- Partnered with the ACS Division of Family Permanency Services' Older Youth Services to deliver annual Safe Sleep Symposium for expectant and parenting foster youth.
- In October 2022, during Infant Safe Sleep Awareness Month, launched a new Infant Safe Sleep public awareness campaign and held Safe Sleep Information and Resource Fairs to distribute free information and resources across NYC.
- Partnered with several NYC government agencies, including the NYC Department of Health and Mental Hygiene, NYC Department for Homeless Services, NYC Housing Authority, NYC Health and Hospitals, NYC Department for the Aging, NYC Fire Department, NYC Police Department and NYC Department of Transportation, and other community stakeholders to deliver infant safe sleep training and distribute educational materials and resources to the parents and caregivers they serve.

In addition to its Safe Sleep outreach, community engagement and training efforts, OSCIP launched a Cannabis Safety Public Awareness social media campaign and distributed lock boxes to promote safely storing medication during National Poison Prevention Week in March 2023.

Homicides

In 2021, the Medical Examiner classified as homicides 10 fatalities (19%) in families known to ACS within the previous decade. The ME classifies a death as homicide when the fatality results from an act of commission or omission by the perpetrator. The number of fatalities due to homicide varies from year to year (for a longitudinal view, see Table 7 in Appendix B). Children in this category varied from less than two months to almost 16 years old. Seven of the children were less than 5 years of age, and of these, three were less than one year old. Blunt trauma to the head and/or torso was noted in five cases, while three other cases noted Battered Child Syndrome.

ACS Enhanced Oversight of High-Risk Cases

ACS remains committed to strengthening its efforts to protect children who are at the greatest risk of physical abuse, including the use of the Accelerated Safety Analysis Protocol (ASAP) and the Heightened Oversight Process (HOP), initiatives that enhance everyday child protective investigative practices by leveraging additional levels of consultation, oversight and supervisory support.

ACS has increased the number of real-time reviews and coaching touch points with staff working on the city's most challenging cases to improve safety-related case practice and reduce the risk of critical incidents and/or fatalities. The reviews also support collection of safety-related data and information that ACS can integrate into its zones, boroughs, and city level continuous quality improvement activities as well as inform agency initiatives.

Also, the ACS Heightened Oversight Process (HOP) created in 2017 remains a key initiative. The HOP combines the expertise of Child Protection Managers and Investigative Consultant Supervisors on the most high-risk cases involving young children. These cases include child fatalities, serious injuries, or sexual abuse of children three years old or younger, as well as cases where there are children three years of age or younger and the parent/caregiver named in the SCR report has had one or more children residing elsewhere, or removed and placed in ACS foster care prior to the current investigation, and the child(ren) and parent have not reunified. The HOP provides a structure for collaboration and consultation among child protection investigative teams and the Investigative Consultants, an ACS team of former NYPD detectives. The HOP identifies an investigative strategy at the beginning of the investigation and ensures all investigative steps are completed, including whether any additional actions are needed.

In addition, amongst its various quality management and quality improvement processes, ACS continues to rely on ChildStat to promote an agency-wide culture of learning and accountability. At ChildStat, ACS leadership discuss performance metrics and case practice, and identify areas for zone, borough, and system-wide attention and improvements.

Enhancing ACS and NYPD Coordination

ACS and NYPD have continued a cross-training program to support greater understanding of child abuse and neglect among law enforcement. More than 350 NYPD domestic violence police officers have completed a two-day training on identifying child abuse and maltreatment taught by the professional development team at the ACS James Satterwhite Academy that is offered each month. So far, twenty members of the NYPD Special Victims Division have taken an ACS Workforce Institute course on integrating the skills and methods of motivational interviewing into their work with families and children. ACS child protective teams are trained on ACS/NYPD joint investigation protocols. And the ACS Investigative Consultant team presents at NYPD promotional trainings (Sergeant, Lieutenant, and Captain Leadership courses).

Improve Processes at the Child Advocacy Centers

ACS, Safe Horizon and NYC Health and Hospitals are partnering to ensure that children who require a medical assessment for possible physical or sexual abuse receive one expeditiously at a Child Advocacy Center (CAC). The CAC, one in each borough, provide a child-friendly, safe, supportive environment where children are seen after allegations of physical or sexual abuse or severe neglect. Operated by Safe Horizon, a multi-disciplinary team of professionals including staff from ACS, the NYPD, the District Attorney's Office, pediatricians and other specialists, conduct forensic interviews and mental health and medical assessments. The primary goal of the CAC is to ensure that children disclosing abuse/neglect are not further victimized. In addition, the CAC provide free high-quality, specialized services for abused/maltreated children and their families.

Natural Deaths

In 2021, 23 percent (n = 12) of the child fatalities were determined by the Medical Examiner to be natural (see Table 8 in Appendix B). The ME determines the manner of death to be natural when disease or a medical condition is the sole cause of death. Examples of common natural causes in child fatalities include acute and chronic bronchial asthma, pneumonia, and congenital conditions.

Of the 12 natural deaths, none of cases was indicated for the fatality allegation at the conclusion of the investigation; two were indicated for other allegations. Two-thirds of the children were male (n= 8, 67%), and eight of the 12 had chronic medical conditions and/or developmental issues. Across all fatality types, the average age of death in 2021 was 3.6 years of age; however, children who experienced natural deaths were older, averaging 5.4 years of age, with half of them being younger than two years old.

Services for Children and Families with Complex Medical and Developmental Needs

The ACS Office of Child and Family Health (OCFH) manages health care issues throughout ACS, providing expert technical assistance to child welfare, juvenile justice, and child care programs. The office also develops and implements strategies to enhance the understanding of medical

issues throughout ACS systems in order to improve case practice and outcomes. This includes work with Health + Hospitals medical consultants on cases in which a child is identified as having a diagnosis or suspicion of a significant cognitive delay, neurological disorder, developmental disability, neurosensory limitation, significant neuromotor limitation, or organ system failure.

Also, in an effort to assist children, youths, parents, caregivers and/or other adults suspected of or diagnosed with an intellectual or developmental disability and involved in the child welfare system, the ACS Developmental Disabilities Unit (DDU) has recruited and hired additional staff that serve as liaisons to the DCP borough offices. Each liaison team member provides case consultation, technical support, resources, and guidance to child protection teams. In addition, the liaisons participate in multi-disciplinary team meetings and child safety conferences and other types of family conferences upon request. The liaisons also interface with borough leadership to facilitate DDU trainings.

System Recommendations and Actions

The safety science approach encourages proactively exploring systemic influences that impact decision making in the moment, with the goal of greatly reducing the likelihood of child fatalities. The review process seeks to identify systemic influences within individual cases and trends across multiple cases. The frequency of systemic influences informs recommendations for child welfare system improvement.

The Child Fatality Review Team screens each child fatality case reported to the SCR for ACS history to determine whether the family was “known” to ACS. Cases with current child protection, foster care or prevention services, or cases closed within the past three years or requested by the Office of the Commissioner are eligible for full review in the Systemic Child Fatality Review Process (SCFR) which includes completing a comprehensive case review, conducting human factors debriefing and mapping sessions, and using a Systems Analysis Scoring Tool to score systemic influences.

In addition to the many specific initiatives detailed in the previous pages, the ACS Systemic Child Fatality Review process identified systemic issues and recommended actions to enhance case practice, protect children and strengthen families. These include:

1) Strengthen work with persons causing harm in intimate partner relationships as well as improve engagement with fathers/males involved with the family.

- The ACS Workforce Institute continues to provide an instructor-led course in the Motivational Interviewing sequence called "Motivational Interviewing: Engaging Fathers" to support child welfare staff in engaging males in the family. In addition, the Workforce Institute offers training on identifying and addressing intimate partner violence where participants gain knowledge and skills to assess and engage the survivor, the person causing harm and their children, as well as safety planning. Furthermore, the New York State Office of Children and Family Services (OCFS) offers a training course on involving the fathers of children in child welfare cases.
- ACS Division of Prevention Services has expanded A Safe Way Forward, an innovative model for addressing intimate partner violence that serves the entire family system, offering trauma-informed case planning and research-informed therapeutic services to the survivor, child(ren), and the person causing harm.

2) Increase communication, coordination and collaboration of teams throughout the child welfare continuum.
    - ACS Family Court Legal Services (FCLS) is updating the agency's Legal Tracking System (LTS) to provide more timely information on court hearing outcomes and inform decision making. In addition, FCLS continues to provide training to child protection staff and offer legal consults when needed.
    - Collaboration and coordination between the ACS Division of Child Protection's Family Service Unit (FSU) and ACS-contracted prevention providers is now routine, with nearly 60 percent of families on Court-Ordered Supervision participating in prevention services. ACS is also working with contracted foster care providers to enhance collaboration with prevention services in order to help move children safely, timely and permanently to reunification.

3) Enhance communication and collaboration with mental health providers and the mental health system, and strengthen direct care staff's skills and knowledge in supporting adults with mental illness.
    - ACS is working with the New York State Office of Mental Health (OMH) to train ACS and contracted agency staff on the services available through the OMH continuum and how to access them.
    - The ACS Workforce Institute continues to train child welfare staff on how to work with families impacted by mental illness, and navigating the mental health system. The ACS Clinical Consultation Team also supports child welfare staff in assessing mental health needs and accessing mental health services.
    - ACS, in consultation with The Motherhood Center, is developing a comprehensive and culturally competent validated set of practice changes to improve maternal mental health outcomes for low-income women experiencing Perinatal Mood and Anxiety Disorders and who are known to child welfare in New York City. The Motherhood Center, a clinical treatment facility, provides

therapeutic services to new and expecting mothers and birthing people experiencing Perinatal Mood and Anxiety Disorders—otherwise known as postpartum depression, as well as postpartum psychosis. Along with patient treatment, the Motherhood Center also provides education and training to medical providers and city/state agencies to better equip them with maternal mental health best practices. ACS will provide resources and training support for child welfare practitioners in ACS and contracted agencies to align with these best practices for responding to Perinatal Mood and Anxiety Disorders.

- In 2022 and 2023, ACS, in partnership with the Motherhood Center, NYU McSilver Institute -Training & Technical Assistance Center (TTAC) and the NY Center for Child Development, offered trainings to ACS (direct service staff and contracted providers) and DHS shelter providers, on Perinatal Mood and Anxiety Disorders, including a focus on perinatal depression, anxiety, Obsessive Compulsive Disorder (OCD), Post-Traumatic Stress Disorder (PTSD) and psychosis. The training included discussions around signs and symptoms of each diagnosis, the root causes, the prevalence of Perinatal Mood and Anxiety Disorders, screening instruments and various effective treatment interventions. The presenters highlighted practice recommendations and provided time to address participants' cases and questions. The learning objectives included for participants to gain a basic understanding of the signs and symptoms of Perinatal Mood and Anxiety Disorders, acquire an understanding of how to screen for and where to refer clients that appear to be experiencing a Perinatal Mood and Anxiety Disorder, and to become familiar with effective treatment interventions.

Appendix A: Manner of Death Definitions

The New York City Office of the Chief Medical Examiner determines both the cause and manner of death for each fatality for which an autopsy is conducted. The cause of death is the injury, disease or condition that resulted in the fatality, such as asthma or blunt trauma. The manner of death is based on the circumstances under which the death occurred. The following are the classifications used by the Medical Examiner:

Homicide: The Medical Examiner determines a death is due to homicide when the death results from an act of commission or omission by another person, or through the negligent conduct of a caregiver.

Natural: The Medical Examiner determines a death to be natural when disease or a medical condition is the sole cause of death.

Accident: The Medical Examiner determines a death to be an accident when the death results from injury caused inadvertently.

Suicide: The Medical Examiner certifies a death as suicide when the death is the result of an action by the decedent with the intent of killing him or herself.

Undetermined: The Medical Examiner certifies a death as undetermined when the manner of death cannot be established with a reasonable degree of medical certainty.

Therapeutic Complications: The Medical Examiner certifies a death from therapeutic complications when the death was due to predictable complications of appropriate medical therapy.

Appendix B: 2021 Data Tables

Table 4. Manner of Death, Fatalities in Families Known to ACS in Previous Decade and Reported to SCR (2012 - 2021)

Manner of Death	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Homicide	15	6	9	10	11	6	10	9	5	10
Undetermined	15	20	17	16	19	16	20	19	23	19
Natural	15	4	21	7	16	28	19	14	16	12
Accident	4	12	9	6	8	11	8	9	8	11
Suicide	1	2	2	2	0	2	2	3	0	0
Therapeutic Complications	0	0	0	1	1	0	0	0	0	0
Pending	0	0	0	[+]1	[+]1	0	0	*3	0	*1
Total per year	50	44	58	43	56	63	59	57	52	53

[+]In one 2015 case and in one 2016 case, no body was found.

*In three 2019 cases and one case in 2021, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 5. Investigation Decision on Fatality Allegations in Families Known to ACS in Previous Decade with Fatality Reported to SCR (2012 - 2021)

Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	Ψ2021
Fatality Allegation Substantiated	23	25	27	13	21	23	25	21	11	17
Other Allegation Indicated (excluding fatality)	11	9	13	13	13	15	13	21	15	10
Unfounded Investigation	16	8	18	17	19	25	19	14	24	26
Total Investigations*	50	42	58	43	53	63	57	56	50	53

* Some investigations involved families with more than one child fatality

ΨFor one case in 2021, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 6. Sleep-Related Child Fatalities in Families Known to ACS in Previous Decade and Reported to SCR (2015 - 2021)

Year of Child Fatality	Number of ACS Known Sleep Related Fatalities	Total Number of ACS Known Fatalities	Percent of ACS Known Fatalities that had Unsafe Sleep Injuries
2015	21	43	49%
2016	21	56	38%
2017	24	63	38%
2018	21	59	36%
2019	20	57	35%
2020	22	52	42%
2021	20	53	38%

Table 7. Homicides in Families Known to ACS in Previous Decade and Reported to SCR (2012 - 2021)

Manner of Death	2012	2013	2014	2015	2016	2017	2018	*2019	2020	*2021
Homicide	15	6	9	10	11	6	10	9	5	10
Total Fatalities	50	44	58	43	56	63	59	57	52	53
Percent of Fatalities Deemed Homicides	30%	14%	16%	23%	20%	10%	17%	16%	10%	19%

*In three 2019 cases and one case in 2021, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 8. Fatalities reported to SCR and Certified as Natural Deaths in Families Known to ACS in Previous Decade (2012 - 2021)

Manner of Death	2012	2013	2014	2015	2016	2017	2018	*2019	*2020	*2021
Natural	15	4	21	7	16	28	19	14	16	12
Total Fatalities	50	44	58	43	56	63	59	57	52	53
Percent of Fatalities Deemed Natural Deaths	30%	9%	36%	16%	29%	44%	32%	25%	31%	23%

*In three 2019 cases and one case in 2021, the Medical Examiner has yet to provide the completed autopsy or determine the manner and cause of death.

Table 9. Race and Ethnicity Demographics of Parents in 2021 Child Fatalities Reported to SCR ǂ

Race/Ethnicity	Families Known to ACS Within Previous Decade		Families With no Prior ACS Involvement	
	Mother	Father	Mother	Father
Asian	5	5	4	3
Black/African American	33	31	19	16
Biracial/Multiracial	0	1	1	0
Hispanic	8	9	16	15
Other	1	0	2	2
N/A*	0	2	0	6
Unknown	0	1	0	0
White	6	4	7	7
Total	53	53	49	49

ǂ 2021 New York City child fatalities reported to the SCR alleging maltreatment associated with the fatality

*N/A = no information is available about the male in the family